REQUEST FOR AGENCY ACTION/ LICENSE APPLICATION

A. IDENTIFYING INFORMATION: *All satellite/branch programs must also fill out Section A.

FACILITY NAME _____ **TELEPHONE#** _____

FACILITY MAILING ADDRESS _____ **FAX #** _____

FACILITY STREET ADDRESS _____ **EMAIL** _____

CITY AND ZIP _____

ADMINISTRATOR _____ **TELEPHONE#** _____

Professional license? Yes ☐ No ☐ Category _____ **Number** _____

EMERGENCY CONTACT PERSON _____ **TELEPHONE#** _____

DATE OF REQUESTED ACTION: FROM _____ **TO** _____

B. ACTION REQUESTED: (Check all that apply T). Application is complete when copies of all items listed are submitted.

Initial License ☐ **(Include fees, fire clearance, certificate of occupancy, zoning, kitchen inspection, CBS initial clearance)**

Annual Renewal ☐ **(Include fees, fire clearance, CBS Renewal form)**

Change Ownership ☐ **(Include agreement, fees, fire clearance, certificate of occupancy, zoning, kitchen inspection, CBS Consent)**

Change Administrator ☐ **(Include name of new administrator, qualifications, fee)**

Change in Location ☐ **(Include fees, fire clearance, certificate of occupancy, zoning, kitchen inspection)**

Change in Name ☐ **(Include fees)**

Change in Capacity ☐ **(Include fees, fire clearance)**

Change in Management ☐

C. TYPE OF FACILITY: (Check appropriate boxes)

☐ **ACUTE HOSPITAL:**

Number of beds Acute _____ **Swing Beds** _____ ***NBICU*** _____ **Other** _____
Type of Emergency Services (Level I - IV) _____
Number of Isolation rooms in Emergency Dept _____
Number of Emergency bays _____ **Level of Nursery Care (Basic, Specialty, Sub-Specialty)** _____

☐ **SATELLITE Type** _____

☐ **SPECIALTY HOSPITAL**

Type _____ ***#of Beds*** _____
Type of Emergency Services (Level I - IV) _____ **Number of Emergency bays** _____
Level of Nursery Care (Basic, Specialty, Sub-Specialty) _____

☐ **NURSING CARE FACILITY # of Beds** _____ **Skilled** _____ **Intermediate** _____ **Secure Unit (yes/no)** _____

☐ **INTERMEDIATE CARE FACILITY FOR MENTALLY RETARDED # of Beds** _____

☐ **SMALL HEALTH CARE FACILITY**

Nursing # of Beds _____ **Type 'N' # of Beds** _____ **ICF/MR # of Beds** _____

☐ **ASSISTED LIVING - TYPE I** **# of Beds** _____ **vs # of Apartments** _____

☐ **ASSISTED LIVING - TYPE II** **# of Beds** _____ **vs # of Apts** _____ **Secure Unit (yes/no)# Beds** _____

☐ **AMBULATORY SURG. CENTER** **# of Surgery Rooms** _____

☐ **BIRTHING CENTER** **# of Birthing Rooms** _____

☐ **ABORTION CLINIC** **# of Surgical Rooms** _____

☐ **END STAGE RENAL DISEASE CENTER** **# of Dialysis Stations** _____

☐ **HOME HEALTH AGENCY** **MAIN OFFICE ☐ BRANCH OFFICE ☐**

☐ **PERSONAL CARE AGENCY** **MAIN OFFICE ☐ BRANCH OFFICE ☐**

☐ **HOSPICE** **INPATIENT ☐ OUTPATIENT ☐ BRANCH OFFICE ☐**

D. VARIANCE CONTINUATION / DEEMED STATUS:

Variance Continuation ☐ Identify Rule: _____

Deemed Status☐ Initiation of Deemed status
Date of accreditation: _____ Accrediting Agency: _____
☐ Continuation of Deemed status

E. OWNERSHIP OF FACILITY: Check One T

☐ Individual proprietorship: (Identify Owner name, address, and persons having ownership)

☐ Corporation: (Identify Corporation name, address; Officers by name, title, address and telephone #)

☐ Partnership: (Identify each partner by name, address and telephone #)

☐ LLC: (Identify LLC name, address; Owners by name, title, address and telephone #)

☐ Other: (Describe the ownership arrangement and identify the owner(s) by name, address and telephone #)

_____

_____

_____

_____

F. OPERATION/MANAGEMENT OF THE FACILITY: Check One T

☐ Individual proprietorship: (Identify Owner name, address, and persons having ownership of 10% or more)

☐ Corporation: (Identify Corporation name, address; Officers by name, title, address and telephone #)

☐ Partnership: (Identify each partner by name, address and telephone #)

☐ LLC: (Identify LLC name, address; Owners by name, title, address and telephone #)

☐ Other: (Describe the ownership arrangement and identify the owner(s) by name, address and telephone #)

_____

_____

_____

_____

Provide the name, address, percentage of stock, shares, partnership or other equity interest of each officer, member of the board of directors, trustees, stockholders, partners, or other persons who have greater than 25 percent interest in the facility:

_____

_____

_____

_____

(USE ADDITIONAL PAGES IF NECESSARY)

Each of the persons listed in E and F have attested to the licensee that they:

a) have never been convicted of a felony;

b) have never been found in violation of any local, state, or federal law which arises from or is otherwise related to the individual's relationship to a health care facility; and

c) have not currently or within the five years prior to the date of application had previous interest in a licensed health care facility that has been any of the following:

- **(i) subject of a patient care receivership action;**
- **(ii) closed as a result of a settlement agreement resulting from a decertification action or a license revocation;**
- **(iii) involuntarily terminated from participation in either Medicaid or Medicare programs; or**
- **(iv) convicted of patient abuse, neglect or exploitation where the facts of the case prove that the licensee failed to provide adequate protection or services for the person to prevent such abuse.**

(Pursuant to R432-2-6(3))

G. CERTIFICATION OF UNDERSTANDING:

I _____, as _____
(Name) (Title)

of the above named facility, understand this request constitutes a Request for Agency Action as specified in Utah Code Ann. 63-46b(3) and serves as the formal document upon which a licensing decision will be based. I agree to abide by the rules promulgated by the State of Utah for this category of health care facility and do hereby state that the information provided on this application is true to the best of my knowledge and belief.

I further understand that I am responsible for admitting and retaining only those persons who qualify as defined in the applicable rules and facility policies and procedures. I agree to allow authorized representatives of the Department of Health, upon presentation of proper identification, to enter the facility at any reasonable time without a warrant and to review facility records and documents as necessary to ascertain compliance with State licensing law and rules promulgated by the Health Facility Committee.

_____ _____
Signature **Date**